

BEFORE THE PERSONNEL APPEALS BOARD

STATE OF WASHINGTON

JOHN HENSON,

Appellant,

v.

DEPARTMENT OF SOCIAL AND HEALTH
SERVICES,

Respondent.

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Case No. DISM-99-0007

FINDINGS OF FACT, CONCLUSIONS OF
LAW AND ORDER OF THE BOARD

I. INTRODUCTION

1.1 Hearing. This appeal came on for hearing before the Personnel Appeals Board, WALTER T. HUBBARD, Chair; GERALD L. MORGEN, Vice Chair; and NATHAN S. FORD, JR., Member. The hearing was held on August 19, 1999, in the Hearing Conference Room at Western State Hospital in Steilacoom, Washington.

1.2 Appearances. Appellant John Henson was present and was represented by Edward E. Younglove III, Attorney at Law, Parr and Younglove, P.L.L.C. Respondent Department of Social and Health Services was represented by Paige Dietrich, Assistant Attorney General.

1.3 Nature of Appeal. This is an appeal from the disciplinary sanction of dismissal for neglect of duty, gross misconduct and willful violation of published employing agency or department of personnel rules or regulations. Respondent alleges that Appellant pushed a patient into a pillar causing a laceration to the patient's forehead, that Appellant disrupted the ward and interfered with the inter-shift report, and that he refused to help staff administer medication.

1.4 **Citations Discussed.** WAC 358-30-170; Baker v. Dep't of Corrections, PAB No. D82-084 (1983); McCurdy v. Dep't of Social & Health Services, PAB No. D86-119 (1987); Rainwater v. School for the Deaf, PAB No. D89-004 (1989); Skaalheim v. Dep't of Social & Health Services, PAB No. D93-053 (1994).

II. FINDINGS OF FACT

2.1 Appellant John Henson was a Mental Health Technician (MHT) 2 and a permanent employee of Respondent Department of Social and Health Services (DSHS) in the Adult Psychiatric Unit at Western State Hospital (WSH). Appellant and Respondent are subject to Chapters 41.06 and 41.64 RCW and the rules promulgated thereunder, Titles 356 and 358 WAC. Appellant filed a timely appeal of his dismissal on February 8, 1999.

2.2 Appellant began employment with DSHS on October 19, 1988. Appellant was a good employee who was well liked by his co-workers and by patients. Although Appellant had not received any previous formal disciplinary actions, he had received a letter of reprimand for voicing his opinion about the way security staff dealt with a patient.

2.3 By letter dated January 22, 1999, Dr. Pat Terry, Acting Chief Executive Officer for Western State Hospital, informed Appellant of his dismissal effective February 2, 1999. Dr. Terry alleged that (1) Appellant pushed patient S. which resulted in a laceration to the patient's forehead and (2) that Appellant subsequently declared in a loud voice, while an inter-shift report was occurring, that he would not help staff administer medication.

2.4 Patient S. was housed on Ward C-4. He was known to be volatile and assaultive. Appellant was S.'s contact person and he was accustomed to dealing with and de-escalating S.'s behavior.

1 2.5 Although Appellant's regular work assignment was on Ward C-4, on August 19, 1998, he
2 was working the evening shift as a fill-in on Ward C-5. During the day shift on August 19, 1998, S.
3 was put in the C-4 seclusion room as a result of his disruptive behavior. After he was out of
4 seclusion, S. continued to be disruptive and confrontational with staff. At approximately 10:10
5 p.m., Avonda Reynolds, Licensed Practical Nurse (LPN) 4, instructed LPN Sandra Sims to call
6 Appellant and ask him to return to Ward C-4 to assist with S.

7
8 2.6 When Appellant arrived on C-4, S. was standing outside of the nurses' station. Appellant
9 attempted to redirect S., but S. continued his disruptive behavior. Chris Thorkildsen, Registered
10 Nurse 2, LPN Reynolds, and LPN Sims, were in the nurses' station. LPN Reynolds suggested to
11 RN Thorkildsen that he assist Appellant. RN Thorkildsen decided that S. should be placed in
12 seclusion and went to assist Appellant with escorting the patient.

13
14 2.7 The following events occurred quickly and were observed by no one other than those
15 directly involved. Based on the credible evidence and testimony, the Board finds as follows.
16 Appellant and RN Thorkildsen attempted to move S. to the seclusion room by maneuvering him
17 through an 8 foot wide area between the nurses' station on the left and a pillar on the right. As
18 Appellant and RN Thorkildsen attempted to move him forward, S. pulled back. S. continued to
19 resist by rocking forward and back on his toes. When they were about three feet from the pillar, S.
20 pulled free from RN Thorkildsen's grasp of his left arm. Because RN Thorkildsen lost his grasp,
21 Appellant released his grasp on S.'s right arm. As a result, S. fell forward, hit his forehead on the
22 pillar, sustained a laceration to his forehead, and fell to the floor.

23
24 2.8 Subsequently, RN Thorkildsen called his supervisor, RN 4 Paul Vilja, and reported the
25 incident. He told RN Vilja that Appellant had pushed S. into the pillar. RN Thorkildsen then wrote
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1 in the patient's progress record that the patient fell into the pillar. Later, he wrote an incident report
2 in which he stated that the patient either fell, slipped or was pushed into the pillar.

3
4 2.9 S. had a reputation for complaining about staff and voicing his concerns. He never accused
5 Appellant of causing his injury or of pushing him into the pillar.

6
7 2.10 Dr. Morrison evaluated S. and determined that S. should be given a sedative by injection
8 prior to him being transported to Ward E-7 for suturing of his laceration. Because the injury to the
9 patient occurred near the end of the evening shift, by the time Dr. Morrison gave his order, the night
10 shift was preparing to come on duty.

11
12 2.11 LPN 3 Vilma Soto worked the night shift on August 19, 1998. When Doctor Morrison's
13 order was given, she had already completed the medication count and she had assumed
14 responsibility for the medications from the evening shift. However, before proceeding to fulfill her
15 responsibility, LPN Reynolds interrupted the inter-shift report to inquire if she had to administer the
16 injection. Because LPN Soto had completed the medication count, LPN Reynolds told LPN Soto
17 that it was her responsibility to administer the injection.

18
19 2.12 As LPN Soto proceeded to S.'s room, Appellant interrupted the inter-shift report to
20 announce that LPN Soto was going to administer the injection. Appellant was concerned because
21 evening shift staff were still on duty, yet LPN Soto, who was assigned to night shift, was
22 administering the medication. LPN Reynolds told Appellant that she'd take care of it and Appellant
23 said okay.

24
25 2.13 Appellant, LPN Saundra Sims, Mental Health Technician (MHT) 1 Dave Puaokalani, and
26 LPN 2 Cora Munar were in the area. As LPN Soto proceeded to S.'s room, she walked past the

1 staff but she did not ask anyone to assist her in administering the injection. However, LPN Sims
2 followed her into the room and tried to assist her. LPN Soto administered the injection before any
3 other staff arrived. MHT Puaokalani and LPN Munar arrived after the injection was administered.
4 The Board finds that based on the credible testimony and evidence, none of the staff, including
5 Appellant, refused to assist LPN Soto.

6
7 2.14 As a result of the incidents of August 19th, a Personnel Conduct Report (PCR) was initiated
8 against Appellant. The PCR alleged that Appellant had pushed S. into a pole which resulted in S.
9 being injured and that Appellant had interfered with the treatment of S. by refusing to participate in
10 his direct patient care. A PCR investigation was conducted and the results of the investigation were
11 forwarded to Dr. Pat Terry, the appointing authority. Dr. Terry reviewed the investigative report
12 and conducted an administrative hearing with Appellant, his representative and representatives of
13 the agency. In addition, Dr. Terry reviewed Appellant's personnel record. Dr. Terry concluded that
14 misconduct had occurred and that because the agency had a zero tolerance policy against patient
15 abuse, she determined that dismissal was the appropriate disciplinary sanction.

16 **III. ARGUMENTS OF THE PARTIES**

17 3.1 Respondent argues that if this case was only about the incident with LPN Soto, dismissal
18 would not have been appropriate. However, while Appellant's actions regarding the administration
19 of the injection were inappropriate, Respondent argues that his dismissal was the result of his abuse
20 of patient S. Respondent contends that regardless of whether Appellant was well liked, the facts
21 and the testimony of RN Thorkildsen prove that Appellant pushed S. into the pillar. Respondent
22 argues that because Appellant abused patient S, dismissal is appropriate.

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24 3.2 Appellant argues that he has a ten-year history of employment at Western State Hospital
25 with no previous allegations of misconduct toward patients. Appellant asserts that he is a capable
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1 employee, he has the support of his co-workers, and he did not intentionally shove or push the
2 patient into the pillar. Appellant further asserts that he was not the only staff person present when
3 LPN Soto went to administer the injection to S., that she did not ask for assistance from staff, and
4 that no other staff were disciplined for not assisting her. In addition, Appellant asserts that the
5 information he shared during the inter-shift report did not interfere with the report process and did
6 not disrupt the ward.

7 8 IV. CONCLUSIONS OF LAW

9 4.1 The Personnel Appeals Board has jurisdiction over the parties hereto and the subject matter
10 herein.

11 4.2 In a hearing on appeal from a disciplinary action, Respondent has the burden of supporting
12 the charges upon which the action was initiated by proving by a preponderance of the credible
13 evidence that Appellant committed the offenses set forth in the disciplinary letter and that the
14 sanction was appropriate under the facts and circumstances. WAC 358-30-170; Baker v. Dep't of
15 Corrections, PAB No. D82-084 (1983).

16
17 4.3 Neglect of duty is established when it is shown that an employee has a duty to his or her
18 employer and that he or she failed to act in a manner consistent with that duty. McCurdy v. Dep't
19 of Social & Health Services, PAB No. D86-119 (1987).

20
21 4.4 Gross misconduct is flagrant misbehavior which adversely affects the agency's ability to
22 carry out its functions. Rainwater v. School for the Deaf, PAB No. D89-004 (1989).

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24 4.5 Willful violation of published employing agency or institution or Personnel Resources
25 Board rules or regulations is established by facts showing the existence and publication of the rules
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1 or regulations, Appellant's knowledge of the rules or regulations, and failure to comply with the
2 rules or regulations. A willful violation presumes a deliberate act. Skaalheim v. Dep't of Social &
3 Health Services, PAB No. D93-053 (1994).

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5 4.6 Respondent failed to meet its burden of proof that Appellant willfully pushed patient S. into
6 the pillar. Respondent failed to meet its burden of proof that Appellant disrupted the inter-shift
7 report or that he refused to assist Ms. Soto in administering the injection to S.

8
9 4.7 Based on the proven facts, the disciplinary sanction of dismissal should be reversed.

10 **V. ORDER**

11 NOW, THEREFORE, IT IS HEREBY ORDERED that the appeal of John Henson is granted.

12
13 DATED this _____ day of _____, 1999.

14 WASHINGTON STATE PERSONNEL APPEALS BOARD

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16 _____
17 Walter T. Hubbard, Chair

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19 _____
20 Gerald L. Morgen, Vice Chair

21 _____
22 Nathan S. Ford Jr., Member

23
24
25
26
Personnel Appeals Board
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